No. 23-1275

IN THE

Supreme Court of the United States

EUNICE MEDINA, in her official capacity as Director, South Carolina Department of Health and Human Services,

Petitioner,

v.

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF 238 MEMBERS OF CONGRESS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

CHRISTOPHER E. BABBITT
Counsel of Record
JAMIE YOOD
NITISHA BARONIA
ANN E. HIMES
MEGHAN G. HOLLOWAY
WILMER CUTLER PICKERING HALE AND DORR LLP
2100 Pennsylvania Avenue N.W.
Washington, D.C. 20037
(202) 663-6000
christopher.babbitt@wilmerhale.com

A complete list of the 47 U.S. Senators and the 191 Members of the U.S. House of Representatives participating as amici curiae is provided as an appendix to this brief. Among them are:

Minority Leader Charles E. Schumer
Sen. Patty Murray
Sen. Ron Wyden

Minority Leader Hakeem Jeffries
Rep. Katherine Clark
Rep. Frank Pallone, Jr.
Rep. Diana DeGette
Rep. Ayanna Pressley

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INTEREST OF AMICI CURIAE[1]

Amici curiae are 238 members of Congress—47 United States Senators and 191 United States Representatives, who represent tens of millions of constituents across 38 States and the District of Columbia that participate in the Medicaid program. *See* Appendix for List of Amici. Amici share an interest in ensuring that the federal Medicaid Act is implemented in accordance with congressional intent, which includes providing Medicaid beneficiaries with the right to choose a qualified, willing provider, *see* 42 U.S.C. § 1396a(a)(23), and ensuring that Medicaid beneficiaries can vindicate that right in federal court under 28 U.S.C. § 1983. Private enforcement of that right is critical to the physical health and safety of Medicaid beneficiaries and consistent with the intent of the Medicaid program. Amici therefore urge this Court to affirm the decision below.

SUMMARY OF ARGUMENT

Congress enacted the free-choice-of-provider provision nearly sixty years ago to ensure that Medicaid beneficiaries would have the right to select among healthcare providers—mandating that "State plan[s] for medical assistance must" enable "any individual" participant to obtain medical care "from any" participating provider "qualified to perform the service." 42 U.S.C. § 1396a(a)(23)(A). The right to select one's own healthcare provider has been a core promise of the program ever since. And for decades, Congress has

[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than Amici Curiae, their members, and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

approved of—indeed, relied on—private enforcement in federal court as a critical means of protecting that right.

A federal statute creates a right that is enforceable under Section 1983 when two criteria are satisfied. First, Congress must have "unambiguously conferred individual rights upon a class of beneficiaries to which the plaintiff belongs." *Health & Hosp. Corp. of Marion Cnty.* v. *Talevski*, 599 U.S. 166, 183 (2023). Second, enforcement of those individual rights under Section 1983 cannot be "incompatible" with an alternative enforcement mechanism created by Congress. *Id.* at 187. As the Fourth, Sixth, Seventh, Ninth, and Tenth Circuits have held, both requirements are satisfied here. *See Planned Parenthood of Kan.* v. *Andersen*, 882 F.3d 1205, 1224-1225 (10th Cir. 2018); *Planned Parenthood Ariz. Inc.* v. *Betlach*, 727 F.3d 960, 965-966 (9th Cir. 2013); *Planned Parenthood of Ind., Inc.* v. *Commissioner of Ind. State Dep't of Health*, 699 F.3d 962, 965-968 (7th Cir. 2012); *Harris* v. *Olszewski*, 442 F.3d 456, 461 (6th Cir. 2006); Pet. App. 26a.

First, the free-choice-of-provider provision unambiguously creates a privately enforceable right. Congress enacted the free-choice-of-provider provision in 1967 to provide Medicaid beneficiaries with the right to choose among qualified healthcare providers. In doing so, Congress deliberately conferred a right upon a distinct and discernable population: Medicaid beneficiaries. *See infra* Part I. Section 1396a(a)(23)'s language reflects this congressional intent. The free-choice-of-provider provision uses "'rights-creating,' individual-centric language with an 'unmistakable focus on the benefited class,'" *Talevski*, 599 U.S. at 183 (quoting *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 284 (2002)); it guarantees that "any individual" eligible for Medicaid services "may obtain

such assistance from any institution" that is qualified and willing to provide those services. Congress established this right with the expectation that it be honored.

Second, enforcement of the free-choice-of-provider provision under Section 1983 is not "incompatible" with an alternative enforcement scheme created by Congress, *Talevski*, 599 U.S. at 186. Indeed, no such alternative enforcement scheme exists. The Medicaid Act offers no other means by which beneficiaries of the Act may challenge a state's compliance with Section 1396a(a)(23), and neither the Centers for Medicare and Medicaid Services ("CMS") nor any state forum can adequately protect beneficiaries' right to choose their qualified provider under federal law. In enacting the free-choice-of-provider provision, Congress *expected* Medicaid beneficiaries to enforce their right to choose providers using Section 1983. And for good reason: Federal courts are the natural forum for people to protect their rights under federal law. In fact, when a decision from this Court called into question Congress's commitment to a private right of action as a Medicaid enforcement tool, Congress amended the Medicaid Act to narrow the circumstances in which it could be read to preclude enforcement through Section 1983. *See* 42 U.S.C. § 1320a-2. The recourse available to beneficiaries is in federal court—and federal courts have a responsibility to protect rights that Congress has affirmatively conferred as a matter of federal law.

For over three decades, Congress has retained the free-choice-of-provider provision and Section 1320a-2's clarification favoring private enforcement. Medicaid remains intact, refuting Petitioners' (and their congressional amici's) baseless claims of financial ruin. Indeed, as states set Medicaid provider rates (subject to federal

criteria), there is no reason that an individual's ability to seek care from their provider of choice would have any financial impact on states or beneficiaries at all. In fact, it is states that have sought to waive Medicaid's free-choice-of-provider provision that have seen a dramatic reduction in access to services and beneficiaries' health suffer.

ARGUMENT

I. THROUGH SECTION 1396a(a)(23), CONGRESS UNAMBIGUOUSLY CONFERRED ON MEDICAID BENEFICIARIES THE RIGHT TO CHOOSE ONE'S OWN QUALIFIED PROVIDER

The first step in determining whether a federal statute can be privately enforced under Section 1983 is to ascertain whether Congress "unambiguously conferred individual rights upon a class of beneficiaries to which the plaintiff belongs." *Health & Hosp. Corp. of Marion Cnty.* v. *Talevski*, 599 U.S. 166, 183 (2023).

The touchstone of the inquiry is congressional intent. "A court's role in discerning whether personal rights exist in the § 1983 context … requires a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries." *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 285 (2002). When the statute at issue "'is phrased in terms of the persons benefited' and contains 'rights-creating,' individual-centric language with an 'unmistakable focus on the benefited class,'" Congress has indicated its unambiguous intent to confer an individual right. *Talevski*, 599 U.S. at 183 (quoting *Gonzaga*, 536 U.S. at 284). Such language is present here.

1. The plain text of the free-choice-of-provider provision bears the hallmarks of a rights-creating statute. Section 1396a(a)(23)(A) speaks in terms of the rights-bearer. It provides a guarantee that a certain set of individuals—Medicaid beneficiaries—can choose among qualified and participating providers:

> A State plan for medical assistance must provide that *any individual* eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required … who undertakes to provide *him* such services… .

42 U.S.C. § 1396a(a)(23)(A) (emphases added). By focusing on Medicaid beneficiaries' ability to select their preferred providers, Section 1396a(a)(23) uses "individual-centric" language "concerned with 'whether the needs of [a] particular person have been satisfied.'" *Gonzaga*, 536 U.S. at 288 (quoting *Blessing* v. *Freestone*, 520 U.S. 329, 343 (1997)). Medicaid beneficiaries do not "merely … fall 'within the general zone of interest that [the free-choice-of-provider-provision] is intended to protect," *Talevski*, 599 U.S. at 183 (quoting *Gonzaga*, 536 U.S. at 283); rather, Medicaid beneficiaries are the intended beneficiaries of this right. *Compare* 42 U.S.C. § 1396a(a)(23)(A) *with Talevski*, 599 U.S. at 184-185 (finding significant that the provisions at issue were written in terms of protections for "residents"). It is of no moment that the free-choice-of-provider provision also imposes on states the obligation to protect Medicaid beneficiaries' ability to select their healthcare provider. As the Court explained in *Talevski*, "it would be strange to hold that a

statutory provision fails to secure rights simply because it considers, alongside the rights bearers, the actors that might threaten those rights." 599 U.S. at 185.

2. Congress's intention to create an individual right is amply reflected in the legislative history. When discussing Section 1396a(a)(23)(A), Congress repeatedly used the same "'rights-creating,' individual-centric language" that it did in the text of the statute itself. *Talevski*, 599 U.S. at 183 (quoting *Gonzaga*, 536 U.S. at 284). And the provision's passage was heralded by members of Congress as providing a specific class—Medicaid beneficiaries—with a right that was heretofore denied to them: the right to choose their own providers.

The free-choice-of-provider provision at issue here has its origins in the Medicare Act, which provides: "*Any individual* entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide *him* such services." 42 U.S.C. § 1395a(a) (emphases added). In fact, the senator who introduced the Medicaid free-choice-of-provider provision as an amendment to the Social Security Amendments of 1965 pointed to Medicare's own provision and explained that it was also necessary for Medicaid, saying that "people who must rely on this program because of insufficient income and resources are entitled to the same prerogatives" as others. 111 Cong. Rec. 15,791 (1965) (statement of Sen. Williams).

The Medicaid program, however, was not originally enacted with the same guarantee that was included in Medicare. The omission resulted in concern among advocates and providers alike about the possibility for excessive state interference in the choice of Medicaid

providers for beneficiaries. During the hearings on the 1967 amendments to the Medicaid program, several professional medical associations testified about early state efforts to limit beneficiaries' ability to select their preferred provider and force them to select from a very limited set of state-run or state-approved providers.[2] Congress enacted the free-choice-of-provider provision in 1967 in response to these concerns.

By adding to the Medicaid Act a similar right to choose among qualified and participating providers as existed in the Medicare Act, Congress decided to provide all Medicaid beneficiaries with the same meaningful choice as Medicare beneficiaries. As the House Committee Report explained:

> Under the current provisions of the law, there is no requirement on the State

[2] *See, e.g.*, *President's Proposals for Revision in the Social Security System: Hearings on H.R. 5710 Before the H. Comm. on Ways & Means*, 90th Cong. 2273 (1967) (Letter from Asociación de Hospitales de Puerto Rico) ("If there is going to be a boss, let the patient be the boss to decide what is best for him. Let us not ourselves be the only and omnipotent arbiters in designating in advance where a needy patient should go and what doctor should take care of him when he is sick."); *id.* at 2301 (Letter from the Massachusetts Medical Society) (testifying that the free-choice-of-provider-provision was "particularly needed in Massachusetts where, because of a Department of Public Welfare regulation, private physicians rendering care to Medicaid beneficiaries in 19 so-called 'teaching hospitals' will not be reimbursed for services actually rendered to such patients."); *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the S. Comm. on Fin.*, 90th Cong. 1597-1604 (1967) (Statement of E. J. Felderman, M.D., President of the Association of New York State Physicians and Dentists) (expressing the concern that states will abuse their authority to determine what providers are qualified to interfere with a beneficiary's "fundamental right" to choose their provider).

> that recipients of medical assistance … have freedom in their choice of medical institution or medical practitioner. In order to provide this freedom, a characteristic of our medical care system in this county, a new provision is included in the law to require States to offer this choice … . Under this provision, an individual is to have a choice from among qualified providers of service.

H.R. Rep. No. 90-544 at 122 (1967); *see also* S. Rep. No. 90-744, at 182-183, 298 (1967) (similar); 113 Cong. Rec. 23,109 (1967) (statement of Gov. Nelson A. Rockefeller) (Through the Medicaid program, "[w]e have also given the people a program which provides for free choice of physician.").

Indeed, both legislators and agency officials have long viewed the Medicaid free-choice-of-provider provision as creating a "right" for enrollees. As noted, Senator John Williams, in a speech introducing the provision as an amendment to the Social Security Amendments of 1965 (Pub. L. 89-97, 79 Stat. 286), stated: "The choice of one's own doctor and other provider of health services is a *right* which should be enjoyed by all Americans." 111 Cong. Rec. 15,791 (1965) (emphasis added). Other senators affirmed this understanding of the free-choice-of-provider provision as establishing a right when they considered adding it to the Social Security Amendments of 1967. *See Social Security Amendments of 1967: Hearings on H.R. 12080 Before the S. Comm. on Fin.*, 90th Cong. 1600 (1967) (statement of Sens. Metcalf and Bennett). Similarly, when testifying about the provision before the House Committee on Ways and Means, Puerto Rico's non-voting House member—whose territory had

not yet enacted Medicaid free choice—emphasized that "[w]ith respect to the 'free choice' requirement … the patient should have the right to choose his doctor and his hospital." *President's Proposals for Revision in the Social Security System: Hearings on H.R. 5710 Before the H. Comm. on Ways & Means*, 90th Cong. 1947 (1967) (testimony of Santiago Polanco-Abreu).

A year after the provision was passed, Senator Jacob Javits noted that a bill he introduced would not interfere with "the patient's right to patronize the community pharmacy of his choice. This right is guaranteed by other sections of the Social Security Act." 114 Cong. Rec. 19237 (1968). The Department of Health, Education, and Welfare ("HEW," today HHS) and the Government Accountability Office ("GAO") concurred with this reading. HEW issued a 1976 letter stating that "free choice of providers of health care is a legal right of every Title XIX [Medicaid] recipient." 122 Cong. Rec. 30,922 (1976) (Acting Commissioner Caughlin July 2, 1976 letter). And in a 1978 report to Congress, the GAO repeatedly referred to "a Medicaid recipient's right to free choice of providers." U.S. Government Accountability Office, *Report to Congress: Savings Available by Contracting for Medicaid Supplies and Services* 19, 24, 27 (July 6, 1978), https://www.gao.gov/assets/hrd-78-60.pdf.

Congress intended for this right to choose among providers to include the right to choose among providers of family planning services. In 1972, Congress amended the Medicaid Act to include family planning services as a required benefit, subject to the free-choice-of-provider provision. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 299E, 86 Stat. 1329, 1462. To be sure, the Medicaid Act has since been amended to allow states to impose greater restrictions on beneficiaries'

choice of providers in the managed care context. *See* 42 U.S.C. § 1396n(b); Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2174, 95 Stat. 357, 809-811. But Congress has specifically maintained Medicaid beneficiaries' right to freely choose among qualified and participating family planning providers notwithstanding these revisions. For example, 42 U.S.C. § 1396n(b) provides that "[n]o waiver [from the free-choice-of-provider provision for state managed care plans] may restrict the choice of the individual in receiving [family planning services]," and 42 U.S.C. §1396a(a)(23)(B) exempts family planning services from abridgment of choice in the managed care setting.

Congress thus enacted the free-choice-of-provider provision in 1967 to provide Medicaid's beneficiaries with a right previously denied to them—the right to choose among qualified health care providers. That promise of choice has remained a core pillar of Medicaid for nearly sixty years. Section 1396a(a)(23) unambiguously confers on beneficiaries a right, the enforcement of which should not be undermined.

3. The members of Congress supporting Petitioner argue (Amici Br. 5-7) that the free-choice-of-provider provision does not unambiguously secure an individual right because Congress enacted the provision pursuant to its spending power. The argument fails for two reasons.

First, just two years ago, in *Talevski*, the Court considered this very question, that is, whether Section 1983 "contains an implicit carveout for laws that Congress enacts via its spending power." 599 U.S. at 171. The Court refused to so hold, rejecting the contract theory on which the argument relies. *Id.* at 171-172. Nothing has changed; that should end the discussion here.

Second, the legislative history of Section 1396a(a)(23) demonstrates that Congress intended for the free-choice-of-provider provision to impose on states a binding obligation to respect beneficiaries' right to choose their providers. Congress consistently discussed the provision in terms of the guarantees it afforded beneficiaries. For example, the House Committee on Ways and Means report regarding the provision explained: Section 1396a(a)(23) conferred upon individuals the right to "have a choice from among qualified providers of service" and that the states would be "require[d] … to offer this choice." H.R. Rep. No. 90-544 at 122. "[W]hen the Congress places requirements in a statute, [it] intend[s] for the States to follow them," regardless of whether the law is enacted pursuant to Congress's spending power. 139 Cong. Rec. S3189 (daily ed. Mar. 18, 1993) (statement of Sen. Riegle). Section 1396a(a)(23) unambiguously confers upon individuals the right to choose their provider; the provision's invocation of spending clause authority is inconsequential. The Court determined as much in *Talevski*, and it should not depart from that precedent now.

II. PRIVATE ENFORCEMENT IS COMPATIBLE WITH CONGRESS'S OTHER ENFORCEMENT MECHANISMS

Once it is established that a federal statute "unambiguously secures rights," courts may "presum[e]" that Congress intended for those rights to be enforceable under Section 1983. *Talevski*, 599 U.S. at 186. To overcome that presumption, Congress must have issued an "implicit[]" "command" to the contrary by establishing a "comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* (quoting *City of Rancho Palos Verdes* v. *Abrams*, 544

U.S. 113, 120 (2005)). Once again, "the inquiry boils down to what Congress intended." *Id.* at 187.

1. Petitioner does not appear to argue that Congress impliedly precluded the rights protected in the free-choice-of-provider provision from being enforceable under Section 1983. Regardless, there is no incompatibility here, because Congress has enacted *no* enforcement tool for Medicaid beneficiaries beyond a private right of action. It has provided for the Secretary of Health and Human Services to restrict Medicaid funds to *states*, 42 U.S.C. §§ 1316(a), 1396c, and for medical providers to challenge their own terminations, *id.* § 1396a(a)(4). But Congress provided a hearing for beneficiaries only when an individual "*claim*" gets "denied or is not acted upon with reasonable promptness." *Id.* § 1396a(a)(3) (emphasis added). Absent from this scheme is any alternative mechanism for beneficiaries to challenge a provider's *disqualification* in violation of the free-choice-of-provider provision. That right belongs to and is properly enforced by beneficiaries, who experience a unique personal injury when their care is denied that is distinct from the business consequences healthcare providers may suffer.

Beneficiaries are therefore best positioned to vindicate their own right to choose their providers, and their "ability to invoke § 1983 cannot be defeated simply by 'the availability of administrative mechanisms to protect the plaintiff's interests,'" *Blessing*, 520 U.S. at 347 (quoting *Golden State Transit Corp.* v. *Los Angeles*, 493 U.S. 103, 106 (1989)). The alternative remedies that Medicaid provides are administrative in nature and are in no way "incompatible" with beneficiary-led Section 1983 claims. For example, the administrative dispute resolution

process—which, after a provider's termination from Medicaid, is available only to providers (not beneficiaries)—is not designed to adjudicate challenges to state *policies* regarding Medicaid qualifications. Where a legal challenge is not about whether the state properly applied a legitimate exclusion (e.g., whether a provider committed patient abuse), but rather about whether the state's termination policy as a whole complies with federal law, federal courts are the appropriate forum.

2. Congress has made clear its view that Section 1983 enforcement of Medicaid's requirements for state plans is perfectly compatible with the broader statutory scheme. In particular, Section 1320a-2 states: "In an action brought to enforce a provision of this chapter"—such as an action enforcing the free-choice-of-provider provision—the "provision is *not to be deemed unenforceable* because of its inclusion in a section … specifying the required contents of a State plan." 42 U.S.C. § 1320a-2 (emphasis added).

Congress enacted this explicit support for private enforceability of Medicaid provisions in response to *Suter* v. *Artist M.*, 503 U.S. 347 (1992), which held that Congress had precluded Section 1983 enforcement of a separate Medicaid provision related to care for children. That decision relied in large part on the reasoning that provisions enabling the Secretary of Health and Human Services to "reduce or eliminate payments" to states for non-compliance (even though they did "not provide a comprehensive enforcement mechanism so as to manifest Congress's intent to foreclose" Section 1983 enforcement) "show[ed] that" such enforcement was not necessary. *Id.* at 360-361.

Section 1320a-2's sponsor explained that it would prevent *Suter*'s reasoning from being "applied broadly to other State plan programs such as Medicaid," and to "make[] it clear that when the Congress places requirements in a statute," it "intend[s] for the States to follow them" and for "the Federal courts [to] order them to comply with the congressional mandate," because they are "the last bastion of protection for the disadvantaged." 139 Cong. Rec. S3189 (statement of Sen. Riegle); *see also* H.R. Rep. No. 103-761, at 926 (1994) (similar).

The provision—which enacts Senator Donald Riegle's bill nearly wholesale—"specifically foreclose[s]" the argument "that federal statutes specifying the requirements of state Medicaid plans cannot impose" Section 1983 liability. *Planned Parenthood of Ind., Inc.* v. *Commissioner of Ind. State Dep't of Health*, 699 F.3d 962, 977 n.9 (7th Cir. 2012). Section 1320a-2 "overturn[s]" the grounds applied in *Suter* for finding unenforceability to return to those "applied in prior Supreme Court decisions respecting such enforceability." 42 U.S.C. § 1320a-2. Those prior decisions—i.e., those Congress acted to codify—held that Medicaid's "administrative scheme," which provides the Secretary only the power "'to audit and cut off federal funds'" is not "sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983." *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 522 (1990) (citing *Wright* v. *City of Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 428 (1987)).

Petitioner (Br. 35) dismisses Section 1320a-2's clear command by inserting words into the statute, claiming it "simply means that a provision 'cannot be deemed individually unenforceable *solely* because of its situs in a

larger regime … specifying the required contents of a state plan.'" (Petitioner's emphasis) (quoting *Midwest Foster Care & Adoption Ass'n* v. *Kincade*, 712 F.3d 1190, 1200 (8th Cir. 2013)). Congress never inserted "solely" into the statute; it instead made clear that courts cannot find unenforceability "because of"—including based in part on—a provision's "inclusion in a section … specifying the required contents of a State plan." 42 U.S.C. § 1320a-2. That congressional command nullifies the bulk of Petitioner's argument (Br. 36) that the Medicaid Act's "articulation of dozens of plan requirements" indicates unenforceability.

3. For decades, courts have cited the free-choice-of-provider provision and Section 1320a-2 to support a longstanding near-consensus that beneficiaries may privately enforce their right to choose a provider. *See, e.g.*, *Planned Parenthood of Ind.*, 699 F.3d at 977 n.9; *Planned Parenthood S. Atl.* v. *Baker*, 941 F.3d 687, 700-701 (4th Cir. 2019). Congress has retained Section 1320a-2 for over three decades and the free-choice-of-provider provision for nearly six. "It is a fundamental principle of statutory interpretation that" a limitation Congress chose not to impose "'cannot be supplied by the courts.'" *Rotkiske* v. *Klemm*, 589 U.S. 8, 14 (2019) (quoting Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* 94 (2012)).

III. THE FREE-CHOICE-OF-PROVIDER PROVISION IS NECESSARY FOR BENEFICIARY HEALTH AND WELLBEING

Congress has, through its enactment, retention, and protection of these statutes, repeatedly rejected Petitioner's policy concerns (Br. 43-44), including their supporting congressional amici's objections about the

"'economic reality' of Medicaid." Members of Congress Cert. Amici Br. 14 (quoting Ison, *Two Wrongs Don't Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care*, 56 Vand. L. Rev. 1479, 1514 (2003)). But states set their own Medicaid provider rates (subject to federal rules), *see* 42 U.S.C. § 1396a(a)(30)(A), so there is no reason that an individual's ability to seek care from their provider of choice would have any financial impact on states at all. As Amici's citation to a 2003 article shows, those policy concerns are far from new; in the decades over which the free-choice-of-provider provision has been privately enforced, the financial calamity they predict has not come to pass, and tens of millions of Americans continue to receive affordable Medicaid coverage.

As explained, Congress has long relied on private enforcers to give teeth to its free-choice-of-provider provision. According to former administrators of the Department of Health and Human Services, "exclusive administrative enforcement of § [1396a] is logistically, practically, legally, and politically unfeasible" because "neither CMS nor HHS has the resources to provide comprehensive oversight of state-by-state compliance." Former HHS Officials Amici Br. 3-4, *Douglas* v. *Indepedent Living Ctr. of S. Cal., Inc.*, No. 09-958 (U.S. Aug. 5, 2011); *see also* Former HHS Officials Amici Br. 9-10, No. 21-806, *Talevski* (U.S. Sept. 23, 2022). Congress made the policy judgment that private enforcement is an appropriate means of enforcing Medicaid's free-choice-of-provider provision.

Tens of millions of Americans, including Amici's constituents, rely on the right to choose among qualified healthcare providers. In 2023, 19 percent of all women

ages 19-64 and 22 percent of all women ages 15-49 relied on Medicaid. *U.S. Women's Health Insurance Coverage Data*, Kaiser Family Found., https://tinyurl.com/mv9ntcya (visited Mar. 12, 2025). Medicaid coverage rates are generally higher among those "in fair or poor health, women of color, single mothers, low-income women, and women who have not completed a high school education." Gomez et al., *Medicaid Coverage for Women*, Kaiser Family Found. (Feb. 17, 2022), https://tinyurl.com/59yuah3s. This makes it all the more important that beneficiaries can avail themselves of federal courts to prevent states from excluding providers based on factors entirely unrelated to competence or program integrity.

When states deny beneficiaries' choice of a qualified Medicaid provider, Amici's constituents suffer. Medicaid beneficiaries often simultaneously receive a range of vital healthcare services in a single visit. For example, they might get an annual "well-woman visit," which is "focus[ed] on preventative care," including a physical exam; preventive services like vaccines; screening tests to check for diseases like breast or cervical cancer, hypertension, or diabetes; and education and counseling; well-woman visits are "usually done by an obstetrician or gynecologist … or another health care professional who has special training in providing care for women." HHS Office of Disease Prevention & Health Promotion, *Get your Well-Woman Visit Every Year*, https://tinyurl.com/xbt6742n (visited Mar. 12, 2025). Limiting Medicaid beneficiaries' access to healthcare providers who specialize in women's healthcare—merely because they separately provide abortion services—limits their access to *all healthcare* and erects false barriers to care.

Texas, for example, took steps beginning in 2011 to reduce funding for, and ultimately fully exclude, Planned Parenthood from its family planning program. *See* Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. Engl. J. Med. 853, 854 (2016). Texas ultimately fully replaced its Medicaid-funded family planning project with a state analog that limited beneficiaries' choice of family planning providers. Beneficiaries' health suffered as a result. Katch et al., *Medicaid Works for Women—But Proposed Cuts Would Have Harsh, Disproportionate Impact* 4, Center on Budget and Policy Priorities (May 11, 2017); Stevenson, 374 N. Engl. J. Med. at 854. "By excluding numerous safety-net health centers and relying primarily on private doctors, [Texas] developed a provider network incapable of serving high volumes of family planning clients. In turn, the state reported a nearly 15% decrease in enrollees statewide over the four-year period." Hasstedt & Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health Care*, Health Affairs Forefront (July 18, 2017), https://tinyurl.com/5dvcxue2 (citing Texas Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* (Mar. 2017), https://tinyurl.com/rfxkjdyr). Further, by 2016, "26% [of] Texas women who the state reported as enrolled in the program had in fact never received health care services from a participating provider, up from only 10% in 2011." *Id.* This dramatic decrease in access to services occurred despite the addition of "thousands more private practices and clinicians" by the State, as these providers serve significantly fewer patients annually than family planning health centers. *Id.*

Private enforcement enables Medicaid beneficiaries to hold states accountable when they accept federal taxpayer money while violating beneficiaries' right to choose the providers on whom that money is spent. Without such individual enforcement, vital healthcare facilities shutter, leaving our least resourced without access to affordable or accessible healthcare. As occurred in Texas, when states arbitrarily limit beneficiaries' choice of providers, beneficiaries lose access to preventative care and face costly—and even deadly—long-term medical consequences.

Congress intentionally established Medicaid beneficiaries' right to receive healthcare services from the provider of their choice when it enacted the free-choice-of-provider provision nearly sixty years ago. That promise to Medicaid beneficiaries should be honored.

CONCLUSION

The Court should affirm the decision below.

Respectfully submitted.

CHRISTOPHER E. BABBITT
Counsel of Record
JAMIE YOOD
NITISHA BARONIA
ANN E. HIMES
MEGHAN G. HOLLOWAY
WILMER CUTLER PICKERING
HALE AND DORR LLP
2100 Pennsylvania Ave., N.W.
Washington, D.C. 20037
(202) 663-6000
christopher.babbitt@wilmerhale.com

MARCH 2025

APPENDIX

APPENDIX

List of Amici Curiae

47 U.S. Senators

Minority Leader Charles E. Schumer
Patty Murray
Ron Wyden

Bernard Sanders
Angela Alsobrooks
Tammy Baldwin
Michael F. Bennet
Richard Blumenthal
Lisa Blunt Rochester
Cory A. Booker
Maria Cantwell
Christopher A. Coons
Catherine Cortez Masto
Tammy Duckworth
Richard J. Durbin
John Fetterman
Ruben Gallego
Kirsten Gillibrand
Margaret Wood Hassan
Martin Heinrich
John W. Hickenlooper
Mazie K. Hirono
Tim Kaine
Mark Kelly
Andy Kim
Angus S. King, Jr.

Amy Klobuchar
Ben Ray Luján
Edward J. Markey
Jeffrey A. Merkley
Christopher S. Murphy
Jon Ossoff
Alex Padilla
Gary C. Peters
Jack Reed
Jacky Rosen
Brian Schatz
Adam B. Schiff
Jeanne Shaheen
Elissa Slotkin
Tina Smith
Chris Van Hollen
Mark Warner
Raphael Warnock
Elizabeth Warren
Peter Welch
Sheldon Whitehouse

191 Members of the U.S. House of Representatives

Minority Leader Hakeem Jeffries
Katherine Clark
Frank Pallone, Jr.
Diana DeGette
Ayanna Pressley

Alma S. Adams, Ph.D.
Pete Aguilar
Gabe Amo
Jake Auchincloss
Becca Balint
Nanette Barragan
Joyce Beatty
Wesley Bell
Ami Bera, M.D.
Donald S. Beyer, Jr.
Suzanne Bonamici
Shontel M. Brown
Julia Brownley
Nikki Budzinski
Janelle Bynum
Salud Carbajal
André Carson
Troy A. Carter, Sr.
Ed Case
Sean Casten
Kathy Castor
Joaquin Castro
Sheila Cherfilus-McCormick
Judy M. Chu
Gilbert Cisneros, Jr.
Yvette D. Clarke
Emanuel Cleaver, II
James E. Clyburn
Steve Cohen
Herb Conaway
Gerald E. Connolly
J. Luis Correa
Jim Costa
Angie Craig
Jasmine Crockett
Jason Crow
Sharice L. Davids
Danny K. Davis
Madeleine Dean
Rosa L. DeLauro
Suzan K. DelBene
Chris Deluzio
Mark DeSaulnier
Maxine Dexter, M.D.
Debbie Dingell
Lloyd Doggett
Sarah Elfreth
Veronica Escobar

Adriano Espaillat
Dwight Evans
Lizzie Fletcher
Bill Foster
Valerie P. Foushee
Lois Frankel
Laura Friedman
Maxwell Alejandro Frost
John Garamendi
Sylvia R. Garcia
Jesús ("Chuy") García
Dan Goldman
Jimmy Gomez
Josh Gottheimer
Al Green
Raúl M. Grijalva
Jahana Hayes
Jim Himes
Steven Horsford
Chrissy Houlahan
Steny H. Hoyer
Val Hoyle
Jared Huffman
Glenn Ivey
Sara Jacobs
Pramila Jayapal
Julie Johnson
Henry C. ("Hank") Johnson, Jr.
Sydney Kamlager-Dove
Marcy Kaptur
Robin L. Kelly
Timothy M. Kennedy
Ro Khanna
Raja Krishnamoorthi
Greg Landsman
John Larson
George Latimer
Summer L. Lee
Susie Lee
Teresa Leger Fernández
Mike Levin
Sam T. Liccardo
Ted W. Lieu
Zoe Lofgren
Stephen F. Lynch
Seth Magaziner
Doris Matsui
Lucy McBath
Sarah McBride
April McClain Delaney
Jennifer McClellan
Betty McCollum
Kristen McDonald Rive
Morgan McGarvey
James P. McGovern
LaMonica McIver
Gregory W. Meeks
Robert Menendez
Grace Meng
Dave Min

Gwen Moore
Joseph Morelle
Kelly Morrison
Seth Moulton
Frank J. Mrvan
Kevin Mullin
Jerrold Nadler
Richard E. Neal
Joe Neguse
Donald Norcross
Eleanor Holmes Norton
Alexandria Ocasio-Cortez
Johnny Olszewski
Ilhan Omar
Jimmy Panetta
Chris Pappas
Nancy Pelosi
Scott H. Peters
Brittany Pettersen
Chellie Pingree
Mark Pocan
Nellie Pou
Mike Quigley
Delia C. Ramirez
Emily Randall
Jamie Raskin
Josh Riley
Luz M. Rivas
Deborah K. Ross
Raul Ruiz, M.D.
Pat Ryan
Andrea Salinas
Linda T. Sánchez
Mary Gay Scanlon
Jan Schakowsky
Bradley Scott Schneider
Hillary J. Scholten
Kim Schrier, M.D.
Robert C. ("Bobby") Scott
Terri A. Sewell
Brad Sherman
Mikie Sherrill
Lateefah Simon
Adam Smith
Eric Sorensen
Darren Soto
Melanie Stansbury
Greg Stanton
Haley Stevens
Marilyn Strickland
Suhas Subramanyam
Thomas R. Suozzi
Eric Swalwell
Emilia Strong Sykes
Mark Takano
Shri Thanedar
Bennie G. Thompson
Mike Thompson
Dina Titus
Rashida Tlaib

Jill N. Tokuda
Paul D. Tonko
Norma J. Torres
Ritchie Torres
Lori Trahan
Derek Tran
Lauren Underwood
Juan Vargas
Gabe Vasquez
Marc A. Veasey
Nydia M. Velázquez
Eugene Simon Vindman
Debbie Wasserman Schultz
Maxine Waters
Bonnie Watson Coleman
George Whitesides
Nikema Williams
Frederica S. Wilson